OPEN MRI CENTERS OF GEORGIA
PATIENT INFORMATION/VERIFICATION

TODAY'S DATE: _____

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____APT # _____

CITY: _____STATE: _____ ZIP: _____

HOME TELEPHONE: _____ MARRIED _____SINGLE _____ DIVORCED _____ WIDOW(ER) _____

DATE OF BIRTH: _____SSN #: _____ MALE: _____ FEMALE: _____

EMPLOYER: _____TELEPHONE: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

PRIMARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____DOB: _____RELATIONSHIP TO INSURED _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

POLICY #: _____ GROUP PLAN #: _____

SECONDARY INSURANCE: _____ PHONE: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

POLICY #: _____ GROUP PLAN #: _____

ATTORNEY NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

REFERRING PHYSICIAN: _____TELEPHONE: _____

DO YOU HAVE A FOLLOW UP APPOINTMENT? YES _____ NO _____IF YES, WHEN? _____

PRIMARY CARE PHYSICIAN: _____TELEPHONE: _____

WOULD YOU LIKE US TO SEND THIS MRI REPORT TO ANY DOCTOR NOT LISTED? _____

IS YOUR CONDITION RELATED TO:

EMPLOYMENT? YES _____ NO _____ INJURY DATE: _____ CLAIM #: _____

ACCIDENT? YES _____ NO _____ INJURY DATE: _____ CLAIM #: _____

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ALL THAT APPLY)

_____ TELEVISION _____ RADIO _____ FRIEND _____ BEEN HERE BEFORE _____ OTHER